Operations for Harelip and Cleft Palate

The Emotional Complications in Children

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• Mothers of children who need reconstructive operations for defects present at birth are likely to feel guilty, particularly if the pregnancy was unwanted. The physician treating the child is in a position to reassure the mother and assuage her guilt.

To the child, the meaning of a surgical experience depends not on the type or seriousness of the actual operation, but on the type and depth of imaginings which it stimulates. For children between two and four, the anxiety of separation from the mother is greater than that aroused by the anesthetic. A good relationship with the mother will insulate the child against many traumatic events.

A surgical operation is an important and stressful experience for a child, activating the great childhood fears of abandonment, of mutilation, and of death. Very frequently, children with harelip and cleft palate, by the time definitive restorative surgery is contemplated, have had emotional experiences that make them more than usually vulnerable to the harmful effects of operation. If the child can discuss the products of his imagination about the operation and have them corrected by someone he trusts, the total response will be more adequate. Talking out and playing out help prevent the development of excessive and harmful emotional reactions.

ANY COMMENTS one might make about the emotional implications in children of operations for harelip and cleft palate are to a large degree a part of the general emotional considerations of operation and anesthesia in children. Before dealing with these general considerations, however, it may be helpful to look upon the bearing that the attitude of the parents, particularly the mother, has upon the problem, and to ponder the effects of the attitude of society towards facial defects.

Harelip seems to be always associated with some degree of facial defect. The disfigurement, even in its mildest form, affects not only the lip but the nose as well. In many cases a mother who has born a child with harelip or cleft palate feels (erroneously) that she is to blame—particularly if she did not wish the pregnancy and tried to disrupt it. Even thoughts of wanting to abort the pregnancy, without actually doing so, may cause a mother to feel irrationally responsible for the child's defect.

The professional persons who assist in her delivery can in some measure lessen these guilt feelings in the mother, as well as the subsequent repercussions of her feelings on the child. The mother should be faced with the facts, the impact of which may be lessened by telling her that it is erroneous for her to think she is responsible for the child's deformity, and that many mothers might feel this way because they feel guilty for not desiring the pregnancy. The obstetrician or other physician is in the position to reassure the mother that corrective operation will improve the defect and the child's facial appearance, and that perfect results may not be needed.

In our culture, the high social premium we place upon physical attractiveness; the tendency of many of us to equate the face, the symbol, with the whole person; the emphasis placed by our mass media of communication on the importance of external appearance—these factors act detrimentally to anyone with a facial disfigurement and may serve to turn even a slight defect into a social and economic handicap. The misconceptions and misinterpretations of society concerning those with facial defects are widespread and have significant influence on the way persons with facial deformity feel about themselves. Hence they are large factors in the development of emotional conflicts. This is not to say that any emotional disturbances present in persons with facial deformities are caused by the defect alone. The elements determining adjustment to facial deformity are interwined with the particular personality, in specific situations and with the sociocultural environment. Parental attitudes are bound to be significantly influenced by those existing in our society towards human beings with a facial defect.

It is wise for a physician to refer a mother for psychiatric help if strong guilt feelings continue. There may be deeper meanings of the feelings of guilt which can be explored only by the psychiatrist. The mother should be encouraged to clarify her own feelings about her guilt, and about the child, so as not to surround the child with the kind of familial emotional climate which will foster his emotional maladjustment. Mothers of children with a defect not infrequently are overanxious and un-

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realistically concerned about the child, even after the defect has been repaired. A destructive cycle tends to be set up in which the mother's guilt causes overconcern; overprotectiveness causes resentment; the resentment, guilt. It is well to remember that parental behavior influences the genesis of emotional maladjustment in a physically normal child, and to an even greater extent in a child with a deformity.

Now as to emotional complications as related to corrective operations. In a surgical procedure there are three main elements: The hospitalization, the anesthesia, and the operation itself. By the time a child is two years of age, any surgical interference with his body may serve as a focus for the stimulation or reactivation of phantasies of being attacked, overwhelmed, having his physical integrity threatened. The action of the surgeon is interpreted by the child in terms of his level of psychic, emotional development. What the experience means does not depend on the type or seriousness of the operation, but on the type and depth of imaginings which it stimulates.

Surgical operations are, to be sure, frightening and upsetting to a child. His ability to handle his emotional reactions is still incomplete; his capacity for testing reality is small; he may be and usually is confused about his own anatomy. For many children anesthesia, narcosis, represents the threat of death. For some, it may mean punishment or execution. Others may fear loss of control during anesthesia—a fear of losing control over one's own impulses, or the fear of losing control over the environment. For some children, pain is terrifying and they will want to avoid it by any means. For these children, the thought of the anesthetic may be reassuring. These considerations, however, apply more to older children. For younger ones, and particularly those between the ages of two and four years, it is probable that the anxiety produced by separation from the mother is greater than that aroused by the anesthetic. The protecting mother is, after all, the main source of security for the young child. As Anna Freud put it, hospitalization, particularly when it is a concomitant of operation, is a serious measure, separating the child from the rightful owner of his body (his mother) at the very moment when this body is threatened by dangers from within and without.

The younger the child, the less comprehension he has of what is to take place. Generally speaking, the younger the child, the less well-equipped he is to handle anxiety on his own; but also, to the extent that he is less a distinct entity in his own right, and more a part of what we call the child-mother unit, the better insulated he is by that unity and by the child-mother relationship—if it is a good one, and if the anxiety of the mother is not so great that it is reflected to the child. The better the child-mother relationship, the more love and security the child has to help him cope with an increased anxiety situation. A good relationship with the mother will insulate the child against many traumatic events, but also the degree of emotional trauma will vary with the tools of mastery of tension at the child's disposal, and this will be different with the age of the child and his previous life experiences.

A study of *separation anxiety* that was done in England during the war years, concluded that hospitals should be built so as to permit parents to remain with children whenever those in charge think it is indicated. But the value of this will obviously depend on the mother-child relationship and the anxiety of the mother. The fact that the mother is in the hospital and will not interfere when something is being done to the child may disturb the child. If the mother's own anxiety is eased, she may be able to give ego support to the child.

In addition to activating the great childhood fears of abandonment, of mutilation and of death, a surgical operation may also stir up ideas of transformation, and of getting a baby. After all, for many children, particularly young ones, hospitals *are* where babies come from.

Generally, it is the child who has a good relationship with his parents who gets the benefit of adequate preparation. Where the relationship between parent and child is hostile or highly conflicted, the mother's attempt at preparation may strengthen the child's feeling that the impending procedure means being sent away or getting punished. It is wise to give the mother a chance to "talk out" her own fears. It is doubtful that preparation by a neurotic mother can be helpful to the child. A mother surrogate, a nurse, a general physician or a psychiatrist may be more useful here.

At best, the unfamiliar preoperative procedures, the strange surroundings and the parental anxiety combine to make the child feel that something terrible is going to happen. He may be permitted little aggressive response to this fear. If he becomes aggressive, he may be threatened, punished, scolded or restrained. Consequently, although he is hostile and frightened, he has to be passive. When he awakes from the anesthetic, he may not know what has happened to him and he imagines the worst. He will usually react with heightened aggression to the motor restraint to which he may be subjected. This will express itself, because it is dammed up, in restlessness, heightened irritability, profane language, etc. The patient's reaction to fear will be the usual one of fight or flight. He may become very angry and want to hurt or destroy those responsible

for his fright. This anger may be expressed verbally, or physically, or he may discharge the fear by playing that he is doing the operation on another child or playing the protecting mother for a doll or young child. Thus he turns the passive role into an active one.

Acknowledgment of the child's fear and expression of his anxiety in play and in talk tend to enhance his assimilation of the experience. Encouraging the child to express his feelings does not mean inviting him to give up control completely. Lack of anxiety is prognostically a bad sign. If the feelings of the child are not openly expressed, either verbally or in physical action, their presence can be detected in his dream life. If an aggressive reaction does not appear or appears and is given up, the child must try to escape. Actually, flight from the fear situation or from the fearful phantasies cannot take place except by the child's submerging his feelings, giving up interest in his surroundings and regressing to simpler and more infantile behavior.

This return to a more childish behavior may be difficult for the adults around him to tolerate. Because the child has submerged his feelings rather than work them out, he may not just develop an aversion to hospitals and anesthesia, which is not so unhealthy. The point is that any future occurrence in which he feels helpless, may reactivate the childhood feelings associated with the earlier traumatic experience so that he behaves inappropriately and with abnormal fear and anxiety in the new situation.

Unlike physical shock, emotional shock may not express itself openly for some time. Therefore, if the child is old enough to talk and understand, it is important that the physician and the parents of a child who is scheduled to undergo an operation, inform him what is going to happen and what he will feel. The opportunity for the child to discuss the products of his imagination about the operation and have them corrected by someone he trusts, helps the total response to be more adequate. Not only before, but also after the operation, the child should be helped to verbalize and to "play out" to the fullest extent his ideas about and his emotional reactions to the operation. Such complete "talking out" and "playing out" is the vital procedure which prevents the development of excessive and harmful emotional reactions, that may result in a lifetime of neurotic unhappiness. All this emotional trauma occurs to some extent even if the surgical procedure is explained to the child and he is allowed to talk out and play out all his ideas and fears, but the phantasies will not be so fully developed, will be less likely to be submerged, and will affect his future reactions less.

Some psychiatrists think that if possible the child should have an opportunity to play out the operation several months before it is to be carried out, but others feel that this is much too long a period of time for a child to stew in the juice of his own imagination. It is not so much the factual information that the child receives that is important as it is the ability of the child to make use of this information to help him master the new situation with which he is confronted. The factual information may be replaced or remodeled by the child's own phantasies. The effectiveness with which the child can use his defenses is influenced by the extent to which the adults around him comprehend that even a minor surgical procedure can have a great emotional impact.

If an operation is necessary but can be postponed for awhile without great danger to the physical health, and if a careful history reveals that the child already shows symptoms of neurosis or has had unusual traumatic experiences—such as deaths in the family, separation from his family, exposure to adverse parental attitudes, or previous surgical treatment to which he has not responded well emotionally—treatment for the neurosis, or study as to whether the child is reacting inadequately to the traumatic situation, should be carried out before the operation is done. The introduction to the operation and the management during convalescence need more careful handling in the case of such a child than in that of a nonneurotic child.

Consideration should be given to so-called minor incidentals which may be of major significance to the child. He should be permitted to bring something from home, whether a toy or a bit of clothing, which for him may be a link to his home and lessen his separation anxiety. There should be a flexible attitude in the hospital. Ward morale is important. Personnel should not use threats about the operation to secure obedience and conformity. Children should not be exposed to unnecessary trauma such as seeing the results of mutilating operations. Other traumatic factors should be avoided whenever possible—such things as the use of routine enemas involving anal stimulation, taking something from the child against his will, the use of rectal thermometers and the routine of no breakfast before operation, with its meaning of oral deprivation to the child.

Finding the optimal time for carrying out an operation on a child becomes an individualized matter involving study of the child in his past and present background, careful preparation before the event, avoidance of separation anxiety, psychiatric or psychiatrically oriented support and facilities for expression of feeling.

The foregoing discussion of general observations with regard to any kind of surgical operations on

children leads to more specific consideration of children with harelip and cleft palate. The guilt, anxiety and ambivalence of the mothers has already been mentioned. It would be an unusual mother indeed who did not have these feelings to some extent because of her having produced a child with a defect, which may well be for her a defective child. The child is bound to react to these parental feelings. By the time definitive restorative operation is done, most of these children will have experienced some degree of personality conflict and heightened self-awareness, which will be influenced not only by the parental attitudes but by the attitudes of the other persons in their environment. Their body image of themselves; their concept of their physical self, cannot help being influenced to a greater or lesser degree. Feelings of inferiority, frustration and inadequacy are not infrequent.

Although opinions differ as to the age at which the things that happen to a child have emotional meaning for him, it is probably safe to say that during the first month of life, which is when repair for harelip now usually is done, the infant's response to the operation will be primarily in physiologic terms. But the experience, although not clearly differentiated for the infant in terms of emotional or psychic meaning, can still be a traumatic one at a physiologic level. An infant is a living, reacting organism, capable of having impressed on its protoplasm the effect of a traumatic experience, and capable of reacting to the behavior of the individuals in his environment, whether it be an anxious mother or an intolerant nurse. The surgeon should be aware of this and should recognize that although the infant can neither talk nor understand, he does react. In this sense, then, it is worthwhile to try to make even this early an experience as untraumatic as possible. This may involve everything from avoiding overstimulating the infant to handling the anxieties of an anxious mother.

There are additional considerations. If a child with harelip gets a plastic repair in the first month of life, the operation eliminates whatever interference with adequate nutrition the defect causes. But a child who has also a cleft palate is not so fortunate, for he has difficulty in regulating respiration. Sucking, feeding and mastication are more difficult. Although so far as is known there have been no long-range studies of the emotional development of such children, it would seem certain that the interference with two functions as vital as breathing and feeding, which are so intimately connected with the emotional development, should significantly influence their emotional life. There is evidence that there is particular anxiety connected with any traumatic procedures involving the mouth. This body area, particularly in young children, is highly charged emotionally. It is the primitive organ of perception and exploration of the world (babies find out about the world and test it by putting everything into their mouths). It is the earliest area for pleasurable satisfaction. It is the portal for the physical nourishment upon which the infant's survival depends. Many adults continue to find their pleasure mainly via the mouth, as in eating, drinking, smoking, or sexual enjoyment. Pain in this region may be especially difficult to tolerate. Immobilization of the mouth is particularly difficult to endure because of its use in eating and breathing and also because it is a primitive weapon of defense.

It seems probable, therefore, that often by the time definitive restorative operation is contemplated, the patient has had emotional experiences that make him more than usually vulnerable to the harmful effects of surgical treatment. There may be little point in correcting a physical defect if the operation increases the emotional maladjustment.

The defect will of course vary in extent and severity. Many of the patients will require multiple surgical procedures, which may extend all the way into adolescence. Some will be more facially disfigured than others. Some will have more understanding and adequate parents. Some will be more adversely affected than others by previous operation. Opinions vary among plastic surgeons as to the best time for repair of cleft palate; some believe it should be done in the first year or later, others as late as the fourth year. There are those who even question whether repair of a cleft palate should be done at all. Some feel that it is essential that operation be performed before speech habits have been formed—before the end of the second year.

Comprehensive care includes speech training after operation as well as whatever orthodontic work may be necessary. The fact that in these children the development of speech is usually delayed, and that before speech training it may not be too intelligible after it develops, increases the difficulty of communication and also the difficulty of attempts to ameliorate the traumatic effects of operation by inducing the patient to "talk out" and "play out" his resentments. The difficulty that others have in understanding the speech of the child has its effect on persons in his environment, which is reflected back to the child. There are other complicating factors, such as diminished hearing and a tendency to ear infections because of a collapsed eustachian tube.

Theoretically the defect or defects should be repaired as early in life as possible, compatible with the physical safety of the child and the minimization of emotional trauma. It may be de-

sirable, whenever possible, to correct a cleft palate before definite speech patterns have formed, for speech patterns are likely to be less defective and speech training more effective. Also, the greater closeness of the child-mother unit when the child is very young may insulate against too harmful emotional effects of an operative procedure. Balanced against this, however, is the fact that at a later age—say three years—the ability of a child to cope with anxiety is better; his understanding is increased, and the possibilities of minimizing emotional trauma by verbalization and "playing out" are increased.

No rule as to time of operation is applicable in all cases. Every child has to be considered on an individual basis, and with a knowledge of the parental attitudes and the emotional climate in which he exists. Obviously such factors as the degree of defect and the probable extent and number of operations have to be considered also.

Although the surgeon who is to operate upon a child for repair of harelip or cleft palate cannot be expected to have the time or the technical skill to carry out the various procedures mentioned to minimize the traumatic emotional impact of operation, he quite probably will feel that it is desirable that this be done. A child psychiatrist would seem to be the logical person to perform this task. Whether a family is able to pay for a plastic operation on a private basis or the child is to be cared for under the auspices of an agency like Crippled Children Services, the services of a child psychiatrist, once they are considered desirable, are possible from an economic point of view. So far as the surgeon is concerned, in either case he can acquire the services of a physician with the professional training and interest to function collaboratively in a team effort to provide as comprehensive care as possible for child and family. The advantages not only for child and parents but also for the surgeon seem obvious. Having someone to cope with an anxious mother and a frightened child, before and after operation, can only make the surgeon's job easier.

One final point. Hospitals do of course have rules, regulations and administrative procedures, some of which are necessary. Nevertheless, flexibility and a reasonable degree of adjustment to the individual patient is desirable. Hospital and ward personnel are not immune to the attitude of the attending physicians, nor are hospital rules and procedures entirely uninfluenced by the stated desires of the professional staff. Hospital personnel, too, need to develop a more comprehensive attitude of mind, which realizes that the child on the ward is not a cleft palate but a total personality who reacts to and is influenced by the attitudes and behavior of those around him. This kind of orientation filters down best to hospital and ward personnel from the top. Usually when the surgeon himself is aware of the emotional implications to child and family of the defect for which he is doing restorative operation, he will see to it that all concerned with the child under his care will be similarly interested in the kind of management of the child that will insure maximum benefit and minimal emotional trauma.

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